Do Not Staple!

KENTUCKY EMPLOYEES' HEALTH PLAN
PY 2010
ENROLLMENT APPLICATION
FOR ACTIVE EMPLOYEES

INSURANCE COORDINATOR SECTION **REQUIRED**

__/__/10 Coverage Effective Date

Company Number

Reason for Application:

☐ New Employee	☐ Open Enrollment	☐ New Group	☐ FSA Only
☐ QE*	☐ Previously Waived *	☐ Other *	☐ Retiree Return to work

* If you previously waived, marked "Other" or "QE" above, enter the Qualifying Event Date AND a description of the Qualifying Event

Date: Qualifying Event Description:

Additional information:

☐ I am covered under my own Hazardous Duty Plan retirement plan	☐ I am covered as a spouse under a Hazardous Duty Retiree's plan	☐ I am covered under a Medicare Supplemental plan through a state sponsored retirement system	☐ I am a dual employee

SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

Smoking Status (Required)

Have you smoked in the last 2 months? ☐ Yes ☐ No

Gender
☐ Male
☐ Female

Marital Status
☐ Married
☐ Single

___ – ___ – ___ Social Security Number

__/__/__ Date of Birth (MM/DD/YYYY)

NAME (First, MI, Last)

Mailing Address

City, State, Zip Code | County of Residence | Country / Mail Code, if not USA

Planholder's HOME Phone Number | Planholder's WORK Phone Number | Planholder's E-mail Address (prefer Work E-mail Address)

Hire Date | Employer Name | Work County

SECTION II: PLAN SELECTION → *If you wish to waive (i.e. decline) coverage, skip to Section V*

1. Option (Check only one)

☐ < Commonwealth Maximum Choice
☐ < Commonwealth Optimum PPO
☐ < Commonwealth Capitol Choice
☐ < Commonwealth Standard PPO

2. Level of Coverage

☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

3. Cross-Reference Payment Option
(Available for Family Coverage Only)

☐ < Yes

If Yes, you must complete Sections III and IV. The employee with the earliest hire date will be the policy holder.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you selected Single coverage, skip to Section VI*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP = Spouse, CH = Child, CO = Court-Ordered Dependent, DD = Disabled Dependent

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, Box 3*

Your Spouse's Company Number: ***(Required)***	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:
_____	☐ ***Yes*** ☐ ***No***	☐ ***Yes*** ☐ ***No***	_____

PY **2010**

Planholder's SSN

SECTION V: WAIVER → *Complete this section only if you did not select coverage in Section II*

Do you wish to waive (i.e. decline) your coverage and have the employer contribution of $175 per month deposited into a Health Reimbursement Account (HRA), ***if eligible***? *(If not eligible, you will be set up as a* ***Waiver, No HRA).*** ☐ ***Yes***
(Participants in the stand-alone, Waiver HRA will receive up to the maximum of $2,100 for the year.)

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA) → Enrollment in an FSA is OPTIONAL

If you are an employee of a health department or certain quasi agencies, this section does not apply to you. You must contact your insurance coordinator regarding your employer's FSA enrollment process.

Healthcare → All amounts must be divisible by two and be listed for a full calendar year. The **maximum** allowable yearly contribution is $5,000; the minimum is $5.00 per paycheck.

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Calendar Year 1/1-12/31 _____	Total Spouse Contribution for Calendar Year 1/1-12/31 _____

Dependent Care → All amounts must be divisible by two. **Maximum** allowable yearly contribution (per family) based on tax filing status

Tax Filing Status:

☐ < Married, filing separately (max = $2,500) ☐ < Married, filing jointly (max = $5,000) ☐ < Single, head of household (max = $5,000)

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
_____ Total Employee Contribution for Plan Year	_____ Total Spouse Contribution for Plan Year

Humana*Access* SM VISA® Card

Upon enrolling in an HRA or a **healthcare** FSA you will receive the HumanaAccess- Visa® card at no cost to you.

SECTION VII: AUTHORIZATION AND CERTIFICATION

I understand that:

* My signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
* **My spouse and I elect the cross-reference payment option, we are dual planholders with Family coverage and that upon a loss of eligibility by either spouse, the remaining planholder will have the option to enroll in either Single or Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.**
* Each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP Handbook.
* All benefits for myself and eligible dependents be provided in accordance with the plan document.
* And agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* The elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe.
* **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents; for Pre-tax treatment, dependent coverage must meet eligibility requirements of Section 152.**
* Enrollment in an FSA is optional and that by completing Section VI of this application, I am enrolling in an FSA, if eligible to participate.
* Regarding my FSA, any dependents for which I claim reimbursement are Section 152 dependents as defined by the Internal Revenue Code.
* Regarding my FSA, any unused amount remaining in my spending account at the end of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document; I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
* My Humana Access Card will be suspended if the required HRA/FSA claim verification is not sent in within thirty (30) days after the Card swipe.
* This Plan reserves the right to deny access to the card, require repayment, deduct/withhold from your paycheck and offset your HRA/FSA accounts if you fail to properly substantiate your HRA/FSA claims.
* This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.

I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage.. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____
Employee Signature **Date**

_____ _____
Spouse Signature – *REQUIRED* if electing the cross-reference payment option **Date**

_____ _____
Employee's Insurance Coordinator Signature **Date**

_____ _____
Spouse's Insurance Coordinator Signature – *REQUIRED* if electing the cross-reference payment option Date